Testimony of Normand E. Deschene, President and CEO of Lowell General Hospital

Good morning Acting Commissioner Carrington, Members of the Legislature, Attorney General's office, representatives and esteemed colleagues on this panel. It is my pleasure to come before you today to represent the interests of Lowell General Hospital; I must clarify that none of my comments today represent the views of the collective membership of the Massachusetts Hospital Association, of which I am the newly elected Chair of the Board of Trustees.

Thank you for inviting me to speak and to be part of the testimony for today's panel as we discuss payment variation among providers in Massachusetts.

As background, Lowell General Hospital is a 217 bed Community Hospital located in the City of Lowell, the fourth largest City in the Commonwealth. It is my 27th year managing Lowell General Hospital, 8 of which as President and Chief Executive Officer. I am proud to represent this important community hospital and offer it as an example of how balancing both cost and quality successfully offers an undeniable value proposition to the Merrimack Valley, local employers and to the insurance industry.

During my tenure at Lowell General, I have experienced first-hand the evolution of the healthcare payment system from cost-based reimbursement to HMO proliferation to P4P and now to Accountable Care. Lowell General has been highly agile at adapting to this ever-changing landscape. Our successful evolution is based upon unwavering core principles, which include compassion, service excellence, an unrelenting focus on quality and nursing, and clinical excellence; all with the underlying focus of remaining **affordable** to our Community.

The private payment system in Massachusetts is a free market system. Although the answer to the question of what causes wide variation in payment rate is complicated, we also believe the greatest determinant is very evident. It is leverage, as defined by market position, location and brand name that has been the largest drivers of the disparity in rates. I do want to point out, however, that the high focus on Academic Medical Centers being paid more than community hospitals is misplaced. The focus should be on what level or degree the premium should be driven by tertiary care and how to create parity for low cost-high quality community hospitals that are under paid. Academic medicine is one of the cornerstones of the Massachusetts healthcare system as well as one of the top three economic drivers. We appreciate and respect that fact. On any given day, from the City of Lowell, as many as 5 people are transferred from Lowell to one of the Boston teaching hospitals. We are thankful for the proximity of the country's best academic medical centers, we are grateful for their capacity to accept patients and for their expertise in caring for some of our very sickest patients. Nonetheless, the disparities in how much we are paid needs to be addressed.

Challenges to Containing Costs:

There are many factors that limit the ability for LGH to contain costs. One of the most problematic issues facing LGH and its affiliated physician hospital organization is the expansion of Provider Physician Networks. The LGH PHO's membership includes 80 PCP's and approximately 200 specialists. Several PHO specialty groups have recently chosen to affiliate with tertiary affiliated provider networks in

exchange for higher fee schedules. This practice has been encouraged by tertiary-related provider organizations and is allowed by many of the private payers. To our knowledge these newly-formed relationships have demonstrated little or minimal clinical integration or efficiencies while primarily serving to drive up the cost of care and destabilize community-based provider networks. One of the unintended consequences of recent rate transparency is the highlighting of the vast disparities among physician fee schedules.

The LGH PHO works collaboratively to maintain its network of physicians, while balancing the needs of the PCP's, Specialists and the Hospital. Migration of any large physician group to other tertiary-related networks results in increased costs which undermines risk arrangements and causing animosity between local PCP's and Specialists. We believe it also opens the door to leakage to higher costs settings for care that could and should be provided locally. We encourage the health plans to look at this practice in light of the cost debate that is taking place.

Strategies to contain costs –

Expansion of Services to Keep People Local

Lowell General has always been subject to extremely competitive market dynamics and as a result has been historically in the lowest quartile of reimbursement from private payers. Approximately 28% of our revenue is from Mass Health and Managed MCO payers and another 35% is from Medicare. LGH's lack of market leverage and its high governmental payer percentage have required that we be highly efficient in the delivery of high quality care. Lowell General is financially stable, with a growing market share and has invested significant capital into the Hospital over the last 7 years. Lowell General has expanded services to include tertiary level cancer services, neurosurgical services, cardiac and vascular services, a Level IIB Special Care Nursery and a Level III Trauma Center. By expanding the breath and scope of services provided, LGH has kept more patients and residents local, which reduces the costs for all, while improving LGH's ability to be a vital and efficient community Hospital.

AQC

Lowell General Hospital has united with its PHO and has signed a five year agreement with Blue Cross Blue Shield of Massachusetts commonly known as the Alternative Quality Contract. The five- year agreement spans from January 1, 2009, to December 31, 2013. The agreement is a full risk arrangement and includes a global payment, budget-based model. Lowell General Hospital has performed extraordinarily well in the first two years of this agreement by bending the cost curve and by dramatically improving quality scores. The cost trend reductions have been derived from several factors, including as referral management, utilization management, and managing high cost services. The referral management program includes reducing out migration from the service area. Referrals to other organizations are processed and reviewed by the Medical Directors of the PHO. Referrals are approved if the service needed is beyond the scope of services provided by LGH (most tertiary care level services), and/or if the patient had an existing relationship with a provider outside the LGH Network and is continuing treatment for that same condition. The referral management program takes advantage of the low cost structure of LGH by stemming the tide of outmigration. The DHCFP's conclusions contained

in its report are true and accurate: every case that leaves LGH that can be take care of at LGH costs the system more.

In addition to referral management, the PHO has worked with the physicians to develop programs to review utilization of high cost areas such as inappropriate use of the Emergency Room, high cost imaging and other testing. Utilization management has been counter- balanced by the quality component of the Alternative Quality Contract. Blue Cross has designed a program to incentivize preventative care, management of chronic conditions and patient experience measures. The physicians and the Hospital work together in partnership on improving the quality measures year over year.

Concluding Comments

In conclusion, it is my belief, however, that we have to migrate toward a system of global payment with meaningful payments tied to quality performance, service excellence and patient outcomes. The current "fee for service system" rewards production rather than outcomes, and bakes in the pricing disparity and further builds the inequities between rich and poor which permeates today's system. Although there has been some criticism of the global payment model, I urge everyone to be patient. Systemic changes to the health care delivery system must be given an opportunity to take root and should not be changed through a regulatory response, which, to use a healthcare analogy, does little to address the causes but only responds to the symptoms. The necessary changes will take time, planning and require that the varied provider constituents work closely together. I encourage the Division and the Legislature to let the free market system design and develop the future.